



CHELMSFORD COMMUNITY EDUCATION

170 Dalton Road

Chelmsford, Massachusetts 01824

Phone: 978-251-5151 ♦ Fax: 978-251-5154

Summer 2011

Dear Parent and/or Guardian:

It is the policy of Chelmsford Community Education Summerfest Program and the Special Education Summer School to administer medication during the day only when necessary. If at any time while your child is enrolled in these programs a medication is required please refer to the following:

The nurse will need the appropriate orders and/or consents in order for your child to receive a medication. These forms can be found on the Community Education web site. Please note that these orders and/or consents must be submitted each new enrollment period.

- **Health Information Form** – This needs to be completed for those children who have any medical conditions. Please also complete the Medication Order Form if you are providing any medications while your child is enrolled.
- **Signed Medication Order Form** – This needs to be obtained and returned for both prescription and non-prescription medications. If this applies, please also fill out the Health Information Form.

Please note: These required forms must be received by the nurse at the Community Education program before your child will be allowed to attend.

All medications must be delivered to the nurse at the Community Education program and picked up by a responsible adult. All medications will be disposed of at the conclusion of the program if they are not picked up by the last day of the Community Education program.

All prescription medication must be in a pharmacy labeled bottle that includes the child's name, name and correct dose of the medication, physician's name and current date. Please ask your pharmacy to provide you with separate bottles. No more than a 30-day supply can be delivered at one time. All non-prescription medications must be in the original manufacturer's container/packaging.

Please call with any questions or concerns.

Thank you for your cooperation.

The Nursing Staff

5/13/11

CHELMSFORD COMMUNITY EDUCATION HEALTH INFORMATION

08/09

Name _____ Birth Date _____ M ___ F ___
Last First M.I.

Address _____ Home phone _____

Mother's Name _____ Home Phone (if different) _____

Cell Phone _____ Work Phone _____

Father's Name _____ Home Phone (if different) _____

Cell Phone _____ Work Phone _____

With whom does the child reside? _____

Additional names and phone numbers to contact in case parent cannot be reached:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Doctors to be notified in case of severe injury:

M.D. _____ Telephone _____

Dentist _____ Telephone _____

Eye Doctor _____ Telephone _____

Hospital you prefer in case of an emergency: _____

Please check the space provided if your child is being treated for any of the following conditions.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Issue | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Wears glasses |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Seizure | <input type="checkbox"/> Bee/Insect Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Spinal | <input type="checkbox"/> Food Allergy |
| <input type="checkbox"/> Bladder control | <input type="checkbox"/> Heart Issue | <input type="checkbox"/> Panic/Anxiety | <input type="checkbox"/> Latex Allergy |
| | | | <input type="checkbox"/> Other |

Does your child have a prescribed inhaler? Yes ___ No ___ Date of last tetanus (DPT) immunization: _____

Recently under doctor's care? If so, what for? _____

Has your child had recent surgery? If so, what type? _____

If your child has an allergy and/or asthma condition, please contact the nurse to discuss care or medication needed.

Additional comments or problems:

PLEASE COMPLETE THE OTHER SIDE ALSO.

**CHELMSFORD COMMUNITY EDUCATION
HEALTH INFORMATION, continued**

Name of Child: _____
PLEASE PRINT (last) (first)

Birth Date: _____ Birthplace: _____

Primary language spoken at home: _____

Names and ages of other children at home: _____

IDENTIFYING INFORMATION:	
EYE COLOR _____	HAIR COLOR _____
HEIGHT _____	WEIGHT _____
SEX _____	RACE _____
IDENTIFYING MARKS _____	

Does your child have any medical constraints which would limit his/her activity while at school? Yes ___ No ___

If yes, please explain: _____

Who will pick up your son/daughter? _____

Names of others who may occasionally pick up: _____

PLEASE NOTE: This **MUST** be answered in order for the school nurse to give Tylenol. Weight is required for dosage.

Do you give permission for the school nurse to administer Tylenol to your child? Yes ___ No ___ Child's Weight _____

Caladryl, Benadryl, Oragel, Vaseline, Sting Relief Wipes, saline eye solutions, Bacitracin, Silvadene Cream, hydrocortisone cream and First Aid Cream are also available for first aid needs and will be administered with signed consent by parent or guardian below.

Medications: All medications must be given to the school nurse by a parent or guardian. Medications for temporary illness or condition will be administered by the school nurse only if medication is received in the original prescription or over-the-counter container and is accompanied by written authorization from parent and physician (forms available in Health Office). List medication(s) your child takes regularly:

I authorize the release of school records to the appropriate school personnel as necessary for health and safety.

Parent's Signature _____ Date _____

PLEASE COMPLETE THE OTHER SIDE ALSO.

Chelmsford Community Education Program Medication Order Form

(effective first day of Summerfest 2011 to start of Summerfest 2012)

Please check if your child attends the SPECIAL EDUCATION SUMMER SCHOOL 2011

Name of Student _____ D.O.B. _____ Sex _____ Wt _____

Allergies: _____

*Diagnosis: _____ *Other Medical Condition(s) _____

*All current medications, doses and administration times: _____

Mother/Guardian's name & contact information: _____

Father/Guardian's name & contact information: _____

Additional Emergency contact: _____

Physician and Parent/Guardian Consent

Date of order _____ Discontinuation Date _____

Name of Licensed Prescriber _____ Phone number _____

Medication(s) to be administered by the Nurse or Designated Personnel:

Dose _____ Route of administration _____ Frequency _____

Time(s) of Administration _____

Specific directions or information for administration _____

Special Storage Requirements: _____

Consent for self administration? ___ Yes ___ No

Please note that if consent is given for self administration by the doctor that it is understood that the doctor has deemed it safe for such administration, and that all appropriate teaching has been completed by the doctor to the child with full understanding/competency noted.

Physician Consent

Date

Parent/Guardian Consent

Date

(Physician's signature must be manual, may not be rubber-stamped, according to the Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices Policy and Guidelines adopted August 1, 1989 and amended December 12, 2001.)

Additional Parent Consent

1. I give permission to the Community Education and/or Special Education Summer School Office Staff and/or Nursing Staff to share information relative to the prescribed medicine administration, e.g., adverse side effects with appropriate personnel as determines necessary for my son's/daughter's health and safety.
Yes _____ No _____ Any restriction on release _____
2. I understand that all medications are to be furnished by a responsible adult in an updated current prescription bottle with a correct/current label intact; that the program staff will not be transferring the medications from site to site but that this paperwork once submitted will be distributed to the appropriate sites; that I may retrieve any medications from the appropriate Chelmsford Community Education sites any time the during operating hours of those sites; and that all medications will be disposed of if they are not picked up within one week following termination of the order or if they are not picked up by the completion of last day of any particular program.
3. I understand that a nurse is not always available and that I need to communicate with the individual site supervisors on a regular basis to ensure my child's medication needs are met especially when the program has field trips.

Signature of Parent/Guardian _____ Date _____

*If not in violation if confidentiality